Basic facts about Medicare

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Medicare is a health insurance program under social security that can help protect you from the high cost of health care. It has two parts—hospital insurance and medical insurance. Both parts of Medicare are briefly described in this leaflet so that you can see how the services covered by each part fit together to help you pay for a wide range of health services and supplies if you become ill or are injured.

Hospital insurance

Hospital insurance can help pay for three kinds of medically necessary care for each benefit period. A benefit period starts the first time you enter a hospital after your hospital insurance begins. It ends whenever you are out of a hospital or other facility that mainly provides skilled nursing or rehabilitation services for 60 consecutive days (including the day of discharge). Then, a new benefit period begins when you go into a hospital again. The benefits described below are renewed each time a new benefit period begins.

- Up to 90 days of inpatient care in any participating hospital—plus up to 60 additional *non-renewable* "reserve" days which you can use if you ever need more than 90 days of inpatient hospital care in a benefit period. (For psychiatric hospital care, there is a lifetime limit of 190 hospital benefit days.)
- Up to 100 days of care in a participating skilled nursing facility if, after a hospital stay, you need inpatient skilled nursing or rehabilitation services and meet certain other conditions.

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- Up to 100 home health "visits" from a participating home health agency within the 12-month period after a hospital or skilled nursing facility stay when prescribed by your physician because you need part-time skilled nursing services or physical or speech therapy, are confined to your home, and meet certain other conditions.

For certain medical conditions, your physician can submit a special certification which will guarantee coverage for a prescribed number of days of skilled nursing facility care or a prescribed number of home health visits after a hospital stay.

Services covered by hospital insurance
During your stay in a hospital or skilled nursing facility, covered services include semiprivate room, regular nursing services, drugs, supplies, and equipment. During a covered inpatient hospital stay, hospital insurance also covers operating room and special services such as intensive care and coronary care, as well as other specialized services that are ordinarily available only in a hospital.

Covered home health services include part-time skilled nursing services, physical therapy, and speech therapy. When you need one or more of these services, covered services can also include occupational therapy, part-time services of home health aides, and medical supplies and appliances furnished by the agency.

Hospital insurance payments
Hospital insurance payments for covered services are made directly to the participating hospital, skilled nursing facility, or home health agency. When you start a

benefit period by going into a hospital, the $160 hospital insurance deductible must be met before any hospital insurance payments can be made. The deductible must be met only once in each benefit period even if you are admitted to a hospital more than once in a benefit period.

Inpatient hospital payments are made for all covered services during the first 60 days in each benefit period. If you need inpatient hospital care for more than 60 days in a benefit period, hospital insurance pays all but $40 a day from the 61st through the 90th day. For your "reserve" days, Medicare pays for all covered services except for $80 a day.

Hospital insurance pays for all covered services in a participating skilled nursing facility for the first 20 days and all but $20 a day for as many as 80 more days of covered care in each benefit period.

Hospital insurance pays the full cost of all covered services furnished by a participating home health agency.

Some services not covered by hospital insurance

Hospital insurance does not pay for:

- Services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Private duty nurses.
- Personal comfort or convenience items (such as telephone, radio, TV furnished at your request).
- First 3 pints of blood in each benefit period. (You do not have to pay for the first 3 pints if you have them replaced through a blood donor plan membership or have someone donate blood for you.)

Hospital insurance does *not* pay for your physician's services and a number of other important health services and supplies which are covered by medical insurance. This is why medical insurance can be important additional protection.

Medical insurance

Medical insurance is financed by monthly premiums paid by people enrolled in this part of Medicare and by the Federal Government. When medical insurance costs increase because of higher charges for medical services, the premium you pay may be increased. But the premium you pay can be increased only if social security cash benefits were increased during the previous year. The premium increase cannot be more than the percentage increase in benefits during the previous year. The Federal Government pays over two-thirds of the total premium cost for medical insurance.

The basic premium is $8.20 a month through June 30, 1979.

If you wait longer than a year to sign up for medical insurance, your monthly premium will be 10 percent higher for each 12-month period you could have had medical insurance but were not enrolled.

Services covered by medical insurance

Medical insurance helps pay for the following medical services and supplies:

- Physicians' services, no matter where you receive them in the United States—in the doctor's office, the hospital, your home, or elsewhere—including medical supplies usually furnished in a doctor's

office, services of the office nurse, and drugs administered as part of your treatment and which you cannot administer yourself.

- Outpatient hospital services—for diagnosis and treatment—in an emergency room or an outpatient clinic of a hospital.
- Up to 100 home health "visits" in each calendar year from a participating home health agency when prescribed by your physician because you need part-time skilled nursing care or physical therapy or speech therapy and are confined to your home. (These visits are in addition to the post-hospital visits covered under hospital insurance.)
- Outpatient physical therapy and speech pathology services—whether or not you are homebound—furnished under supervision of participating hospitals, skilled nursing facilities, home health agencies, or approved clinics, rehabilitation agencies, or public health agencies under a plan established and periodically reviewed by a doctor.
- Other medical and health services prescribed by your doctor such as diagnostic services; X-ray or other radiation treatments; surgical dressings, colostomy supplies, splints, casts, braces; artificial limbs and eyes; and rental or purchase of medically necessary durable medical equipment for use in your home such as a wheelchair or oxygen equipment.
- Certain ambulance services.
- Limited services by chiropractors.
- Limited home and office services by a licensed physical therapist.

Medical insurance payments

Each year, as soon as you have $60 in "reasonable charges" for covered medical expenses (the $60 annual deductible), medical insurance will pay 80 percent of the reasonable charges for all covered services you receive for the rest of the year regardless of the number of bills you have. There are four exceptions to this general payment rule:

- While you are a hospital inpatient, medical insurance pays 100 percent of the reasonable charges for services by doctors in the fields of pathology and radiology—whether or not you have met the annual deductible.
- After you meet the deductible, medical insurance pays 100 percent of the reasonable charges for home health services.
- Medical insurance payment for services of independent physical therapists is limited to a maximum of $80 in reasonable charges during any one year.
- Physicians' psychiatric services outside a hospital are covered under a special payment rule and medical insurance payment is limited to a maximum of $250 in reasonable charges during any one year.

Medical insurance payments are based on reasonable charges, which are determined by Medicare carriers—health insurance organizations selected by the Federal Government to handle medical insurance claims. Reasonable charges are based on the customary charges of the physician or supplier furnishing covered services but cannot be higher than the prevailing charges—the charges most commonly made by other physicians or suppliers in your area for these services.

Reasonable charges are updated annually, but increases in prevailing charges from year to year are limited by an "economic index" formula which relates doctors' fee increases to actual increases in the cost of maintaining a practice and raises in general earnings levels. This formula does not limit the amount a doctor may charge a patient. It only limits the amount Medicare can pay.

Because of the way reasonable charges are determined under the law, they may be lower than the actual charges made by physicians and suppliers.

Services not covered by medical insurance

Medical insurance does *not* cover certain services and supplies. For example, payment cannot be made for:

- Services or supplies that are not necessary for the diagnosis or treatment of an illness or injury.
- Routine physical examinations and tests directly related to such examinations.
- Prescription drugs and patent medicines.
- Eyeglasses and eye examinations for fitting eyeglasses.
- Hearing aids and examinations for hearing aids.
- Immunizations.
- Dentures and routine dental care.
- Orthopedic shoes.
- Services provided outside the United States (with certain exceptions in Canada and Mexico).
- Personal comfort items.
- The first 3 pints of blood received in each calendar year. (You do not have to pay for the first 3 pints if you have them replaced through a blood donor plan membership or have someone donate blood for you.)

Cancellation and re-enrollment
You may cancel your medical insurance by filing a written notice. Your protection and your obligation to pay premiums will stop at the end of the calendar quarter after the quarter in which your notice is received. We suggest you get in touch with a social security office if you are considering cancellation.

People who are not entitled to hospital insurance automatically, but who enroll and pay premiums for *both* hospital and medical insurance cannot cancel their medical insurance without having their hospital insurance canceled at the same time. However, these people can cancel the hospital insurance part of their coverage at any time by filing a written notice. Their hospital insurance protection and the obligation to pay hospital insurance premiums will stop at the end of the month after the month the notice is received.

If either hospital insurance or medical insurance is canceled, you may re-enroll only once.

Medicare cannot cancel either your hospital or medical insurance coverage without your agreement (or failure to pay premiums), unless your Medicare coverage is based on disability or permanent kidney failure and your entitlement terminates before you reach age 65.

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If you have other health care protection
Many private health insurance companies point out that their policies for people entitled to Medicare are designed only to supplement Medicare. They recommend that their policyholders sign up for medical insurance under Medicare to get full protection. Even if you have other insurance, it may not pay for some medical services that are covered by Medicare, such as treatment at your doctor's office or house calls. If you have other health insurance, you may want to get in touch with your insurance agent or the office where you pay health insurance premiums to discuss your health insurance needs in relation to Medicare protection. This is particularly important if you have dependents who are covered under your present policy. Be sure, however, not to cancel any health insurance you now have for your own protection until the month your Medicare coverage begins.

If you have health care protection from any other source—for example, if you get your health care through the Veterans Administration, the Indian Health Service, a Federal employees' health plan, a State medical assistance program or through any other program or agency—we suggest you get further information from the people there to help you decide whether it is to your advantage to also have Medicare protection.

For more information about Medicare
If you have questions, please call any social security office. The people there will be glad to help you.

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